Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MARCUS PAUL HAYES

Respondent Name
TPCIGA FOR FREESTONE INSURANCE

MFDR Tracking Number
M4-11-4191-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
July 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I did not receive a response within the accepted time frame, so I submitted a request for reconsideration via fax. The IC again did not respond within the accepted time frame (Rule 133.250(f) as noted in the request for reconsideration)."

Amount in Dispute: $432.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Hayes indicates in the dispute that he submitted a request for reconsideration and that he faxed it to 972-503-9388. The correct fax number that this request should have been sent to is 972-233-0191. With this being the case, this is the first time that we are receiving the request for request for reconsideration."

Response Submitted by: Dallas National Insurance Co., 5501 LBJ Freeway, Suite 1200, Dallas, Texas 75240

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2011	Functional Capacity Evaluation	$432.00	$402.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for Worker's Compensation specific services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   1. 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   2. 1 – Time expended on or the number of Functional Capacity Evaluations has been exceeded. (M359)

Issues

1. Did the health care provider exceed limitations on the time expended on or number of functional capacity evaluations allowed?
2. Are the disputed services subject to a contracted fee arrangement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code 1 – "Time expended on or the number of Functional Capacity Evaluations has been exceeded. (M359)" Division rule at 28 Texas Administrative Code §134.204(g) requires, in pertinent part, that "A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. . . . Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test." Review of the submitted information finds no documentation to support that the health care provider exceeded limitations as to time expended on or number of functional capacity evaluations as set forth in §134.204(g). The insurance carrier's denial reason is not supported.
2. The insurance carrier denied disputed services with reason code 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."; with additional notation that "This bill was reviewed in accordance with your Fee for Service contract with First Health." No documentation was found to support that a negotiated or contracted amount that complies with Labor Code §413.011 is applicable to the services in this dispute. The insurance carrier has not supported this payment reduction reason. The disputed services will therefore be reviewed for reimbursement in accordance with applicable Division rules and fee guidelines.
3. This dispute involves Workers' Compensation specific services related to a Functional Capacity Examination with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(g), which requires, in pertinent part, that "FCEs shall be billed using CPT Code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title." 28 Texas Administrative Code §134.203(c)(1) requires that "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."
4. Reimbursement for the disputed services is calculated as follows: Procedure code 97750-FC, service date April 12, 2011, represents a professional service with reimbursement determined per §134.203(c)(1). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, performed in Bexar County, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.943 is 0.41492. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.9355 is 0.028065. The sum of 0.892985 is multiplied by the Division conversion factor of $54.54 for a MAR of $48.70. Per Medicare's Physician Fee Schedule, procedure code 97750 has a multiple procedure payment policy indicator of 5, which designates services subject to multiple therapy procedure payment reduction. Per Medicare policy, when more than one unit of designated therapy services is performed in an office setting on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. The first unit for this procedure is paid at $48.70. The PE reduced rate is $44.18; this amount at 8 units is $353.44. The total MAR is $402.14.
5. The total recommended payment for the services in dispute is $402.14. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $402.14. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $402.14.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $402.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.